Chapter 9 Substance Abuse and Victimization

Abstract

The use and/or abuse of alcohol and other drugs are frequently involved in the commission of some crimes. In addition, some victims use substances as a negative coping mechanism to deal with the short- and long-term trauma of victimization. Collaborative efforts among professionals who serve victims-including victim service providers, criminal and juvenile justice professionals, child protection agencies, mental health professionals, and substance abuse treatment providers-are necessary to promote early identification, prevention, and intervention efforts relevant to victimization and substance abuse.

Learning Objectives

Upon completion of this section, students will understand the following concepts:

- Clinical definitions of substance-related disorders, including use, abuse, and dependence.
- Current research findings relevant to the abuse of alcohol and other drugs and victimization as applied to specific victim populations, including victims of domestic violence and sexual assault, and child and adolescent victims.
- The correlation between victimization, posttraumatic stress disorder, and substance abuse.
- Responses for victim interventions and assistance.
- Promising practices in preventing and responding to substance abuse among victims of crime.

Introduction

Traditionally, the topic of substance abuse within the context of criminal justice has focused primarily on offenders, and the correlation between substance use/abuse and the commission of crimes. In the 1990s, a different and critical emphasis focused on substance abuse among victims, primarily those who are victims of or witnesses to domestic violence and child abuse.

Current research suggests the need for greater attention to the issues of substance abuse among crime victims and those who serve them. The use, abuse, or dependency of victims on legal (alcohol and prescription drugs) or illegal (illicit drugs) substances may precede the criminal activity, occur during the commission of a crime, or develop after the crime has occurred, most often as a delayed reaction associated with trauma. Increased understanding of the linkages between substance abuse and victimization can lead to more effective prevention efforts and improved responses by victim assistance and justice

professionals, mental health providers, and substance abuse treatment professionals to help individuals cope with the trauma of victimization.

These are sensitive concerns that people are aware exist but are hesitant to discuss or address in a meaningful way. Both victimization and substance abuse carry weighty societal stigmas, and when the stigma of victimization is combined with the stigma of substance abuse, victims can fall prey to a "double-edged sword." Moreover, substance use or abuse by victims may be viewed as a "reason" for their victimization, which is an erroneous and potentially harmful assessment within the contexts of both criminal/juvenile justice and mental health services.

While victim service providers should not be expected to be experts in substance abuse assessment and treatment, they should be familiar with professionals and agencies that possess such knowledge and skills. Collaboration is key to preventing and responding to victims who develop dependencies or abuse alcohol and other drugs as a means of coping with the trauma of victimization. This chapter raises issues relevant to substance abuse and victimization in a predominantly exploratory fashion, with emphasis upon collaborative strategies for victim service providers in conjunction with allied victim-serving professionals.

The Need for Research and Services Evaluation

The interface between substance abuse, mental health, and victimization was first addressed in 1985 by a colloquium convened by the National Institute of Mental Health (NIMH) and the National Organization for Victim Assistance (NOVA). The *Final Statement of the Assessment Panel from a Services Research and Evaluation Colloquium* specifically addressed substance abuse as "an area in victim services in need of further research and services evaluation":

> Research is needed that can assist in the development of more effective means of treating substance abuse by crime victims. Such research may show that treatment strategies need to differ according to whether victim involvement in substance abuse preceded the crime event, developed soon after the crime event, or emerged as a delayed reaction to stresses induced by the crime event. On the question of the role of substance abuse in the development of posttraumatic stress disorder, there appears to be little research on the relationship between substance abuse and the development or treatment of PTSD prior to the decision to seek treatment.
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> There are a number of research implications which require investigation. The major issues include, but are not limited to, the role of substance abuse in both the victim, as well as the victimizer. National data indicate that a large percentage of persons who commit crimes have drug or alcohol problems.

> Another issue is the use, either appropriate or inappropriate, of drugs or alcohol in self-medication to reduce stress and anxiety. Additionally, for those individuals who do develop PTSD, a careful review of the past and current substance use/abuse patterns needs to be undertaken. . . .
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> . . . With regard to children, racial groups, ethnic groups and other minority groups, specific research is required which examines the role of substance use/abuse with victims in general and PTSD specifically.

Fortunately, there has been considerable research on these topics since the NIMH/NOVA recommendations, model policies, and training programs have been developed as well.

Serving Victims with Drug and Alcohol Abuse

Crime victims with substance use problems, like people with substance use problems in general, can be challenging and difficult to deal with. Because of the substance use problems, some substance abusing crime victims exhibit disruptive inconsistent behavior that makes it difficult to like or trust them. Many victim service professional have issues about people with substance use problems either because of their own struggles with substance use or those of family members. Although attitudes about substance use problems have become more enlightened as medical sciences has yielded information about what cause and maintains maladaptive substance use, many people still believe that substance abuse is caused b moral weakness. If you think that substance abuse is caused by moral weakness, you are also likely to see substance abusers as morally weak people who deserve little respect or compassion.

There is much still to be learned about risk and protective factors for substance use problems, but modern science has demonstrated that problematic substance use is not caused by moral weakness. Instead, it is caused and maintained by a complex interaction of genetic and constitutional factors, exposure to environmental stressors such as violent crime or child maltreatment, and lack of a supportive environment. As will be described subsequently, history of child maltreatment and violent crime victimization increases risk of substance use disorders. Violent crime victimization and child maltreatment also increase risk of other mental disorders such as posttraumatic stress disorder (PTSD) and depression that are comorbid with and increase the risk of substance use problems. Thus, it is not surprising that many crime victims have substance use problems.

Victim service professionals are not mental health professionals or experts in assessment and treatment of substance use disorders. Nor should they be expected to be. However, it is important that they have some basic knowledge about substance use problems as well as knowledge about resources for substance abuse treatment for crime victims with substance abuse problems.

Perhaps most importantly, victim service professionals need to approach crime victims with substance use problems with as much compassion as possible, as difficult as that sometimes may be. Serving these crime victims effectively requires victim service professionals to transcend any negative attitudes about substance abuse and abusers and to work collaboratively with substance abuse and/or mental health professionals to insure that crime-related substance use problems are properly addressed.

Recent studies have shown a particularly potent and maladaptive *combination of PTSD and substance abuse* in some crime victims. To understand the problem of substance abuse in crime victims, one must begin by understanding how it is related to trauma and PTSD. To lay the groundwork for understanding this relationship, a brief overview of (1) clinical definitions pertaining to substance abuse, and (2) research relevant to substance abuse and victimization, is in order.

Clinical Definitions

There are important and significant differences between substance "abuse," "dependence," and "use" that should be understood in the context of both research and practical applications in victim assistance:

DEFINITIONS FOR SUBSTANCE-RELATED DISORDERS

In the Diagnostic and Statistical Manual-IV (DSM-IV) published by the American Psychiatric Association (1994), "substance-related disorders" include disorders related to the taking of a drug of abuse (including alcohol), as well as disorders related to the side effects of a medication and to toxin exposure. The substances discussed in this section are grouped into eleven classes: alcohol; amphetamine or similarly acting sympathomimetics; caffeine; cannabis; cocaine; hallucinogens; inhalants; nicotine; opioids; phencyclidine (PCP) or similarly acting arylcyclohexylamines; and sedatives, hypnotics, or anxiolytics.

DSM-IV CRITERIA FOR SUBSTANCE DEPENDENCE

A maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by *three (or more)* of the following, occurring at any time in the same twelve-month period:

- Tolerance, as defined by either of the following:
    - A need for markedly increased amounts of the substance to achieve intoxication or desired effect.
    - Markedly diminished effect with continued use of the same amount of the substance.
- Withdrawal, as manifested by either of the following:
    - The characteristic withdrawal syndrome for the substance.

    - The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.
- The substance is often taken in larger amounts or over a longer period than was intended.
- There is a persistent desire or unsuccessful efforts to cut down or control substance use.
- A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), to use the substance (e.g., chain smoking), or to recover from the effects of the substance.
- Important social, occupational, or recreational activities are reduced or given up because of substance use.
- The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).

DSM-IV CRITERIA FOR SUBSTANCE ABUSE

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by *one (or more)* of the following occurring within a twelve-month period:

- Recurrent substance use resulting in a failure to fulfill major role obligations at work, school, or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions, or expulsions from school; neglect of children or household).
- Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).
- Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct).
- Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

DEFINITIONS FOR ALCOHOL USE

- *Current use*. At least one drink in the past month (includes binge and heavy use).
- *Binge use*. Five or more drinks on the same occasion at least once in the past month (includes heavy use).

- *Heavy use*. Five or more drinks on the same occasion on at least five different days in the past month (SAMHSA 1998)
- *Moderate Drinking*. Two drinks a day for men, and only one drink a day for women and anyone age 65 and over (NIAAA 1992).

According to the DSM-IV diagnostic criteria, substance dependence is viewed as the most serious substance use disorder because there is evidence of physical addiction to the substance as demonstrated by tolerance or withdrawal. Substance abuse does not involve physical addiction but is diagnosed when substance use produces extreme distress, impairment in work or personal relationships, legal problems, or use in dangerous situations. Substance use is defined on the basis of any use, but problem use definitions differ somewhat depending on the type of substance involved. Any use of illicit drugs is illegal, as is unauthorized use of prescription medications. Because of the illegal nature of such drug use, any use may be viewed as problematic. In contrast to illicit drugs, alcohol use is legal for adults. Thus heavy use of alcohol that does not rise to the level of dependence or abuse is defined as problematic. This includes both heavy use per se and binge use.

Research Findings Relevant to the Abuse of Alcohol and Other Drugs and Victimization

GENERAL SUBSTANCE DEPENDENCE/ABUSE

A substantial number of adults and youth in America are dependent upon or abuse alcohol and other drugs. The cost of alcohol and drug abuse to society in terms of public and mental health, as well as economic costs, is staggering:

- At least 4.5 million women are alcohol abusers or alcoholics; 3.1 million regularly use illicit drugs; 3.5 million misuse prescription drugs; and 21.5 million smoke cigarettes (Reid 1996).
- Of the 23.1 million persons who used an illicit drug in the past year, 1.9 million reported some health problem due to their illicit drug use; 3.5 million reported an emotional or psychological problem due to their drug use; and 4.1 million were dependent on an illicit drug. An estimated 963,000 had received treatment or counseling for their drug use (SAMHSA 1998).
- 9.7 million people were estimated to be dependent on alcohol, including 915,000 youths ages twelve to seventeen. An estimated 1.7 million people (including 148,000 youths) reported receiving treatment or counseling (Ibid.).
- In 1995, the estimated annual cost of alcohol abuse in the U.S. was $166.5 billion, and drug abuse is estimated to have cost $109.8 billion. Alcohol use disorders cost $56.7 billion more than the estimated annual economic cost of illegal drug use (Harwood et al. 1998).

- Alcohol abuse was involved in over 70 percent of substance abuse treatment admissions in 1997, and about half of people entering treatment reported alcohol as their primary drug of abuse (SAMHSA 1999b).
- The 1997 National Treatment Improvement Evaluation Study of addiction treatment effectiveness found a 70 percent reduction in the number of clients reporting problems with alcohol in the year following treatment (SAMHSA 1997a).

DOMESTIC VIOLENCE AND SUBSTANCE ABUSE

Research indicates a significant correlation between substance abuse and domestic violence victims. The presence of alcohol or other drugs in domestic violence incidents raises important concerns about victims' safety and their capacity to respond to threats or acts of violence. It does *not* mean, however, that the presence of such substances *caused* the abuse to occur. Moreover, substance abuse is sometimes wrongly considered by law enforcement, justice professionals, substance abuse treatment professionals, and batterers intervention professionals to be a *causal*, as opposed to *correlating*, factor in domestic violence within the framework of both the abuser and the victim.

The following facts represent several findings about the correlation between substance abuse and domestic violence:

- Being a victim of domestic violence is associated with an increased incidence of substance abuse (Miller, Downs, Testa, & Panek 1990, as cited by Goldberg 1995).
- Approximately 50 percent of all female alcoholics have been victims of domestic violence (Miller & Downs 1993).
- In a research study conducted by medical personnel and researchers who accompanied police in Memphis as they responded to nighttime calls for assistance, 42 percent of victims of domestic violence used alcohol or drugs on the day of the assault according to their own reports or reports of family members. Fifteen percent had used cocaine, and about half of those using cocaine said their batterers had forced them to use it (Brookhoff 1997).
- In a study of murder in families, half of the victims in spouse murders had consumed alcohol before the crime (Dawson & Langan 1994).
- Having a partner who abuses chemicals is more likely to generate substance abuse in women (Wilsnack & Wilsnack 1991, as cited by Goldberg 1995).
- A batterer may also be the victim's drug supplier, which complicates the situation (SAMHSA 1997b).
- Drug- or alcohol-involved victims of partner abuse may not be taken as seriously by professionals (Stark & Flitcraft 1991). Substance abuse may be viewed as a reason for the abuse, and this is often an inaccurate assessment (Kurz & Stark 1988).

- Victims of domestic violence are more likely to receive prescriptions for and become dependent on tranquilizers, sedatives, stimulants, and painkillers and are more likely to abuse alcohol (SAMHSA 1997b).

SEXUAL ASSAULT AND SUBSTANCE ABUSE

Alcohol and other drugs are often present in both victims and offenders of sexual assault. Similar to crimes of domestic violence, this can wrongly be construed as a *causal* rather than a *correlating* factor to the offense. There is overwhelming evidence that victims of sexual assault and rape are much more likely to use alcohol and other drugs to cope with the trauma of victimization than nonvictims:

- Rape victims were 5.3 times more likely than nonvictims to have used prescription drugs nonmedically (Kilpatrick, Edmunds, and Seymour 1992).
- Rape victims were 3.4 times more likely to have used marijuana than nonvictims (Ibid.).
- Victims of rape were six times more likely to have used cocaine than their counterparts who were not raped (Ibid.).
- Compared to women who had not been raped, rape victims were 10.1 times more likely to have used "hard drugs" other than cocaine (Ibid.).
- Drinking by the victim, the assailant, or both is involved in over half of sexual assaults (BJS 1998).

SUBSTANCE ABUSE, ADOLESCENTS, AND ADOLESCENT VICTIMS

Research reveals that adolescents who use and abuse substances are more prone to serious psychological and behavioral problems. Youth who are victimized by physical or sexual abuse are much more likely to develop substance abuse/dependence:

- In a nationally representative sample, youth who experienced either physical or sexual abuse or assault were twice as likely as their nonvictimized peers to report past-year alcohol or other drug abuse or dependence (Kilpatrick et al. 2000).
- This same national study found that youth who witnessed violence (including domestic violence and violence among their peers) were three times as likely to experience substance use disorders (Ibid.).
- Among 12-to-17-year-old current drinkers, 31 percent had extreme levels of psychological distress, and 39 percent exhibited serious behavioral problems (SAMHSA 1999a).

In 1995, the National Crime Victims Research and Treatment Center at the Medical University of South Carolina conducted the first-ever National Study of Adolescents (NSA) that examined victimization, mental health, and substance abuse issues among teenagers. A telephonic survey of 4,023 adolescents ages

twelve to seventeen determined that, based on U.S. Census 1995 estimates of the U.S. population of adolescents of 22.3 million: 1.8 million adolescents have been sexually assaulted; 3.9 million have been physically assaulted; 2.1 million have been subjected to physically abusive punishment; and 8.8 million have witnessed violence. Significantly, over one half of adolescent victims said that their first use of substances occurred *after* the year they were first assaulted (53.8% for alcohol, 47.8% for marijuana, and 63.5% for hard drugs).

Much of the knowledge gained from the NSA raises crucial issues that cross over lines of research, policy, and practice. As such, collaborative efforts to address these concerns should be encouraged among professionals in the fields of victim assistance, criminal and juvenile justice, mental health, and substance abuse. Among the many NSA recommendations for public policymakers are three that are specific to youth victimization and substance abuse:

1. The NSA found that many violence victims had comorbid PTSD and substance use/abuse/dependence problems, and that victimization is an important pathway to substance abuse and delinquency. These findings imply that effective mental health treatment for adolescent victims is important not only to relieve post-victimization mental health problems, but also to prevent future substance use and delinquent or criminal behavior. Therefore, mechanisms should be developed to ensure that funding is available to provide mental health counseling to adolescent victims who need it, irrespective of their ability to pay or whether they qualify for crime victim compensation.
2. Policies should promote the primary and secondary prevention of child victimization as part of a comprehensive plan for preventing youth substance use and delinquency. Effective and efficient prevention begins as early as possible in the risk factor chain. Results of this study suggest that victimization and its effects are strong and primary correlates with youth substance abuse and delinquency, even when controlling for other risk factors. Therefore, prevention of these early primary experiences will contribute to preventing these secondary problems.
3. Policies should encourage early identification of and intervention with victimized children (secondary and tertiary prevention). All child victimizations cannot be prevented. However, if more can be recognized and effective interventions provided to child victims, it is likely that at least some of the long-term negative effects leading to substance use and delinquency can be mitigated. Therefore, policies should encourage proactive-rather than reactive-approaches to identifying victimized youth, and should promote effective and rapid intervention for victimization-related problems that are related to the development of substance use and delinquency.

The NSA's emphasis on collaborative initiatives to respond to substance use and abuse among adolescent victims extended to practitioners as well, with three important recommendations:

1. Mental health professionals who work with children and adolescents should be informed about the high rates of victimization that occur among children and adolescents, and about the extent to which victimization serves as a risk factor for PTSD, substance use/abuse/dependence, and delinquency. In addition, they should be encouraged to screen for victimization experiences among child and adolescent clients. Substance abuse treatment programs for adolescents should do likewise.
2. Victim assistance professionals in the criminal and juvenile justice systems should establish relationships with mental health professionals who are knowledgeable about crime victims' mental health issues. Criminal and juvenile justice practitioners and victim service providers should establish or enhance professional relationships with substance abuse professionals in order to effectively address issues of substance use, abuse, and dependency among adolescents and children who have been victimized.
3. Mental health programs dealing with child victims should incorporate substance abuse and delinquency prevention components into their protocols. While mental health programs designed to reduce common psychological problems associated with child victimization are common, few include specific interventions for reducing substance use onset, substance abuse, or conduct and delinquency problems. Given the findings of the NSA, mental health programs should incorporate these prevention components as a regular part of their victimization treatment protocols (Kilpatrick et al. 1998).

SUBSTANCE ABUSE AND CHILD VICTIMS

Research reveals that when alcohol and other drugs are present in family environments, the likelihood of child victimization increases. A significant proportion of substance abusing mothers who are involved in child abuse and neglect cases reports childhood victimization:

- According to the National Committee to Prevent Child Abuse (NCPCA), 81 % of all states in 1995 listed substance abuse as one of the primary problems characterizing child protective service cases (NCPCA 1996).
- In a study of substance-abusing women who were admitted for services sponsored by the New York City Administration for Child Services-the public agency responsible for responding to reports of child abuse or neglect-24 percent of the women reported having been sexually abused and 45 percent reported having been physically abused in their childhoods. Of those who reported experiencing childhood sexual or physical abuse, 82 percent were victimized by relatives; 16 percent were

victimized by someone they knew; and 2 percent were victimized by strangers (Kang et al. 1999).

- Risk factors associated with substance abuse disorders include histories of childhood abuse and neglect (Carlson 1997). In fact, a study found that adults with histories of child abuse have an increased likelihood of heart disease, cancer, and chronic lung disease and greater risk for alcoholism, drug abuse, depression, and attempted suicide (Felitti et al. 1998). These findings emphasize the importance of comprehensive screening and assessment for individuals with substance abuse disorders and client access to adequate health care (CSAT and SAMHSA 2000).

SUBSTANCE ABUSE AND HOMICIDE

Research reveals that the sudden and violent loss of a loved one can increase one's propensity to use or abuse substances in order to cope with the trauma resulting from an unexpected and emotionally devastating victimization.

In "Bereavement After Homicide: A Comparison of Treatment Seekers and Refusers" (1995), Dr. E. K. (Ted) Rynearson, Director of Separation and Loss Services of the Virginia Mason Medical Center in Seattle, cites several recent well-controlled studies that have demonstrated the co-occurrence of trauma and bereavement responses with substance abuse (15-20%). The explanation for this co-occurrence is presumably due to multiple factors, including: (1) a number of symptom criteria overlap and (2) an increased risk of the development of psychiatric disorders pursuant to the occurrence of a traumatic event, such as homicide. It is critical for victim advocates and allied professionals to be aware of the high incidence of coexistent psychiatric disorders following trauma or loss. It is particularly important for advocates to be aware of symptoms that indicate the need for appropriate mental health, substance abuse, or other treatment referral.

Victimization, PTSD, and Substance Abuse: A Strong Correlation

SUBSTANCE ABUSE/DEPENDENCE AS A PRE-VICTIMIZATION FACTOR

There is considerable empirical evidence that use of alcohol and other illicit drugs increases one's likelihood of being victimized:

- Women's use of drugs nearly doubled the likelihood they would experience an assault when compared with those who did not use drugs. The greatest risk was to women who used drugs and had experienced an assault previously (Kilpatrick et al. 1997).
- The odds of being assaulted for hard drug users and marijuana users were 5.06 and 1.46 times those of nonusers, respectively (Cottler et al. 1992).
- In a study of an urban population of young adults, the odds of experiencing traumatic events in individuals with alcohol or drug use

problems were 1.47 and 1.79 times those of individuals without such substance use problems, respectively (Breslau et al. 1991).
- Alcohol and drug abusers are about 1.5 times as likely to experience traumatic events as nonusers (Kessler et al. 1995).

There is clearly a significant body of research that shows alcohol and other drugs to be present in the systems of perpetrators and some victims during the commission of many crimes. As noted earlier, for victims of crime, this creates a "double-edged sword" in which the stigma of victimization is exacerbated by the stigma of being under the influence of some type of substance. This double stigma can often affect the provision of treatment and the response of the criminal justice system.

It is critical to note that the research cited above supports substance abuse among some victims at the time of the crime as a *correlating,* and not a *causal,* factor. (This distinction is discussed in detail from a research standpoint in Chapter 17, *Research and Evaluation*.) In environments where alcohol or other substance abuse is occurring, the likelihood of criminal activity may be greater. However, a person's use or abuse of substances *in no way* equates to a basis for blaming that person for his or her victimization by another. Rather, substance use or abuse may impair an individual's perception, judgment, and mental faculties, and often may then have a detrimental effect on his or her ability to maintain personal safety. Because of the devastating effects of societal blaming of victims and substance abusers, this problem needs to be acknowledged and thoroughly addressed by victim advocates.

Stigma against substance abusing/dependent women. Societal and individual attitudes about and stigma against women who are chemically dependent detrimentally affect the access to and provision of all types of supportive services. Furthermore, most treatment modalities have been based on the needs of male substance abusers whose histories and recovery-related issues are likely to be significantly different from women. The stigma against abusing/dependent women can be seen in the following issues (Goldberg 1995):

- Cultural stereotypes of women perpetuate the idea that it is worse for a woman to get drunk (or use drugs) than for a man, with the implication that she may be less deserving of help.
- Most substance abuse treatment approaches are based on models developed for men. Women needing treatment often also have the responsibility of caring for children, making participation in treatment programs (especially residential programs) more difficult.
- Substance abusing women tend to have fewer economic resources for obtaining treatment. Also, they are more likely to have complicating health needs, including pregnancy.

- Generally, women take a shorter period of time than men to go from occasional substance use to abuse, and thus begin to suffer social and physical consequences.
- The criminalization of substance abuse during pregnancy has made many pregnant substance abusing women reluctant to seek treatment.
- Having a substance abuse problem may exclude victims from domestic violence services.
- Women in recovery are likely to have a history of violent trauma and are at high risk of being diagnosed with PTSD (SAMHSA 1997b).

The stigma against women with substance use problems is much worse when they are also the victims of domestic violence; as noted above, this is true for 50 percent of all substance dependent women. Despite this significant correlation between domestic violence and substance use problems, hardly any research has been conducted and little has been written about the need to develop intervention strategies that simultaneously address both the batterer's substance abuse and domestic violence. Even though there is often substance abuse group treatment for men in domestic violence programs, most of it is traditional substance abuse treatment with little focus on the domestic violence issues. Similarly, little has been done to assist battered women with chemical dependency problems in order to meet their needs for both safety and sobriety. *Neither system* is currently equipped to provide the range of services needed by battered women and batterers who are chemically dependent. The issue of cross-training and integrated assessment will be discussed below in "Responses for Victim Interventions and Assessment."

In the addictions treatment system, misinformation often leads counselors to understand and respond to domestic violence through the use of an addiction's "hard love" framework, an approach that has particularly harmful consequences for battered women. Such an approach identifies battering either as a symptom of abuse or addiction-or as an addiction itself. The interventions that follow are based on the erroneous belief that correlation equals causation. The significant correlation between substance abuse and domestic violence denotes *some* connection between the two, but gives no clear picture of causation; it is entirely possible that some third factor is causing this relationship. Much research is needed in this area before conclusions can be drawn about this relationship. Even if there is shown to be some type of causation, this would indicate that a new paradigm of treatment is necessary to effectively treat both issues simultaneously.

This erroneous belief of causation often leads to interventions based on a number of harmful, false assumptions by substance abuse counselors:

- *Alcohol use or alcoholism causes men to batter*. It may predispose a person to violence, but the causes of any crime are always multiple and

complex. The presence of two problems simply means *both* need to be treated-not excused.

- *Alcoholism treatment alone will adequately address the domestic violence issue*. Traditional treatment almost never addresses this issue directly; only in the discussion of taking full responsibility for "the wreckage of the past" is it generally addressed.
- *Battered women are "co-dependent" and thus contribute to the continuation of the abuse*. This mixes and corrupts concepts. In traditional alcohol treatment, a battered woman may be "co-dependent" regarding the substance abuse. This concept has nothing to do with domestic violence, and it was *never* meant to be used to remove the responsibility for the substance abuse (or any other problem, such as battering) from the substance abuser.
- *Addicted battered women must get sober before they can begin to address their victimization*. Both issues must be treated simultaneously. (Note the National Institute of Drug Abuse Principle #3 on page 20.)

SUBSTANCE ABUSE AS A POST-VICTIMIZATION FACTOR

Research reveals that the trauma of victimization leads a considerable number of victims to use alcohol and other drugs as a means of coping with the trauma:

- Nearly nine in ten treatment seeking alcoholic women were physically or sexually abused as children (Miller & Downs 1993).
- Exposure to sexual or physical abuse often contributes to the development of a variety of short- and long-term psychological disturbances, for example, PTSD, depression, anxiety, anger, self-destructiveness, suicidal behavior, low self-esteem, and difficulties with interpersonal relationships (Gil-Rivas, Fiorentine, & Anglin 1996).
- Women who have been assaulted are twice as likely as nonassaulted women to use or abuse substances (Kilpatrick et al. 1997).
- Of the adult women receiving substance abuse treatment in the 1999 National Treatment Improvement Evaluation Study, 43 percent reported having been sexually abused. Significantly more of these sexually abused women also reported physical abuse, mental health problems, suicide attempts, and poor general health-all of which could be potential obstacles to successful substance abuse treatment. In spite of these additional problems, sexually abused women did as well in treatment as nonabused women (CSAT October 1999).
- When a highly specific diagnostic instrument was employed to assess victimization history among treatment seeking substance abusers, 65 % of the women and 16 % of the men reported a history of sexual assault (Grice, Dustan, & Brady 1992).

There are several comprehensive and well designed community surveys that have documented the strong prevalence of PTSD in crime victims. The most

recent (Breslau, et al. 1998) surveyed over 2,000 young adults in metropolitan Detroit to measure the frequency and recovery rate of PTSD responses after all kinds of trauma. The analysis confirmed the findings of another large community survey (Resnick, et. al. 1993).

Findings indicated the following:

- Crime victims who suffered more brutal trauma showed higher frequencies of PTSD: rape (49%), torture (54%), badly beaten (32%), and sexual assault (24%).
- Overall, assaultive violence of all kinds had the highest risk of PTSD (21%) compared with other traumas (9%).
- Women's risk of PTSD following exposure to any trauma was twice as high as men's.
- Twenty-six percent of PTSD cases had improved by six months, 40 percent by one year, and 50 percent by two years. In more than one-third of the cases, PTSD persisted for more than five years.
- Women who had been directly exposed to trauma were a highest risk for nonrecovery.

Drug and alcohol abuse is strongly associated with PTSD. A recent article (Stewart 1996) presents a critical review of over 300 clinical studies that demonstrate a highly positive correlation between trauma, PTSD, and alcohol abuse.

- Alcohol and drug abuse is the most prevalent of all psychiatric disorders in the United States-16 percent of the population.
- Alcohol abusers report three times as much trauma as nondrinkers.
- Studies show a much stronger association with PTSD and alcohol abuse than with trauma exposure alone.
- PTSD signs and symptoms precede the development of alcohol abuse, suggesting that PTSD somehow promotes abuse.
- Studies show a high degree of coexistence between PTSD and alcohol abuse-40 to 70 percent of subjects with PTSD will also have a diagnosis of alcohol abuse.

Victimization, PTSD, and Substance Abuse: A Preliminary Conceptual Model

Because of their exposure to trauma, crime victims are at high risk of developing PTSD (20% or one of every five victims-a conservative average) and at additional risk of abusing drugs and alcohol (three or four times the normal prevalence) if the PTSD persists-as it will for over one-third of the cases. Extrapolating from these frequencies brings the stark realization that *many thousands* of crime victims are at high risk for presenting with the comorbid

disorders of PTSD and alcohol abuse. If they remain untreated, these absolute numbers would be accumulative.

Research from the National Center for PTSD (1999) clearly demonstrates that PTSD and alcohol abuse is potentially a very serious problem for crime victims and their families:

1. PTSD and alcohol problems often occur together. People with PTSD are more likely than others of similar background to have alcohol use disorders both before and after being diagnosed with PTSD, and people with alcohol use disorders often also have PTSD.

    - 25 to 75 percent of survivors of abusive or violent trauma report problematic alcohol use.
    - 10 to 33 percent of survivors of accidental, illness, or disaster trauma report problematic alcohol use, especially if troubled by persistent health problems or pain.
    - Being diagnosed with PTSD increases the risk of developing an alcohol use disorder.

2. Alcohol problems often lead to trauma and also disrupt relationships. Persons with alcohol use disorders are more likely than others of similar background to experience psychological trauma and to have problems with conflict and intimacy in relationships.

    - Women exposed to trauma show an increased risk for an alcohol use disorder even if they are not experiencing PTSD.
    - Women with problematic alcohol use are more likely than other women to have been sexually abused at some point in their life.
    - Men and women reporting sexual abuse have higher rates of alcohol and drug use disorders than other men and women.
    - Problematic alcohol use is associated with a chaotic lifestyle, which reduces family emotional closeness, increases family conflict, and reduces parenting abilities.

3. PTSD symptoms often are worsened by alcohol use. Although alcohol can provide a short-term feeling of distraction and relief, it also reduces the ability to concentrate, to enjoy life and be productive, to sleep restfully, and to cope with trauma memories and stress. Alcohol use and intoxication also increase emotional numbing, social isolation, anger and irritability, depression, and the feeling of needing to be on guard (hypervigilance).

    - Alcohol use disorders reduce the effectiveness of PTSD treatment.
    - Many individuals with PTSD experience sleep disturbances (trouble falling asleep or waking up after they fall asleep). When a person

with PTSD experiences sleep disturbances, using alcohol as a way to "self medicate" becomes a "two edged sword": it may help with one sleep-related problem but exacerbate another.

- Alcohol use may decrease the severity and the number of frightening nightmares commonly experienced in PTSD, but may continue the cycle of avoidance found in PTSD. When a person withdraws from alcohol, nightmares often increase.

Longitudinal studies have shown that PTSD often precedes drug and alcohol abuse. Drugs and alcohol are abused as a maladaptive effort to self-medicate-to moderate the traumatic signs and symptoms of the trauma. Some individuals are incapable of accommodating themselves to the involuntary fear and intrusions of flashbacks and nightmares that interfere with sleep. "Using" drugs or alcohol as a tranquilizer or hypnotic is a short-term solution that may introduce a long-term problem. Abruptly discontinuing drugs or alcohol after several weeks of daily use will create a state of "rebound" in which the central nervous system is suddenly free of the inhibiting effects of whatever substance has been abused. That will begin an intense resurgence of the trauma responses that reinforces the need for continual abuse. When this cycle of abuse to control the mental distress of trauma becomes persistent and maladaptive, it is difficult to interrupt because it has now become the primary way that the victim can calm his or her mind from the mental effects of the crime.

Responses for Victim Interventions and Assessment

EDUCATION

Crime victims, and those who provide support services to them, need to know the basic interactive effects of trauma, PTSD, and substance abuse, as highlighted in this chapter. Education will bring a recognition and identification of crime victims presenting with these disorders and their maladaptive combination.

The combination of criminal victimization and substance abuse presents a "double-edged sword" for victims and practitioners. In general, societal attitudes toward both tend to be negative. There is a need for public education about victimization and its negative effects on individuals, families, and communities, and the need for a societal response that makes victim assistance and support a community-wide priority for government, the private sector, and individuals.

PROMOTE RESEARCH AND EDUCATION SPECIFIC TO SUBSTANCE ABUSE AMONG WOMEN

The "double stigma" of substance abuse and victimization, particularly among women, needs to be addressed in a context appropriate for practitioners and society in general. In his article entitled "Substance-abusing Women: False Stereotypes and Real Needs," M. E. Goldberg (1995) offers insights into

approaches that dispel myths and focus on what is known about substance abuse and women:

> The most desirable type of remedy is prevention of substance abuse among women. Prevention programs should include not only educational programs in schools, such as programs focused on the dangers of substance abuse to unborn children and special risk factors affecting women, but also real efforts to reduce some major risk factors to women. Prevention of sexual and physical abuse of girls would be a major contribution of the prevention of substance abuse in women. Better treatment techniques for adults who sexually or physically abuse children would also be helpful. Generalized efforts to increase the self esteem of women and their ability to act independently of male partners would also be useful in preventing the development of substance abuse problems in women.

Additional research on the causes of women's substance abuse is also very important to improve treatments designed for women. In addition, much substance abuse occurs in individuals who are concurrently experiencing other psychological disorders, the so-called "dual diagnosis" patients. It is essential to learn how the psychological disorders of women, especially depression, interact with substance abuse to aid in the development of treatment for the many women who use substances to self-medicate (Goldberg 1995).

REORIENTATION

PTSD and substance abuse are so prevalent with crime victims that any personnel providing supportive services would be negligent in:

- Ignoring the maladaptive effects of PTSD and substance abuse-that "it will get better on its own" despite hard evidence that it won't.
- Denying the destructive impact of PTSD and substance abuse-sometimes related to the provider's denial of his or her own substance abuse problem.
- Remaining uninformed about the criteria for suspecting the presence of these disorders and the mechanism and resources for appropriate referral.

AGENCY POLICY: CROSS TRAINING AND INTEGRATED ASSESSMENT

The professions of mental health, substance abuse treatment, criminal and juvenile justice, and victim assistance all possess unique and differing expertise and perspectives about victimization and substance abuse. When these sources of knowledge and expertise remain isolated, it is crime victims who suffer the often devastating consequences. Crime victims, and those who provide support services to them, need to know the very basic interactive effects of trauma, PTSD, and substance abuse. Education will bring a recognition and identification

of crime victims presenting with these disorders and their maladaptive combinations.

The existing knowledge base needs to be shared among professions to promote a wide understanding of the many issues relevant to victimization and substance abuse. There is considerable, yet segmented, expertise in all professions with whom crime victims interact. By combining the various sources of knowledge, victim-serving professionals can increase their capacity to effectively help victims with substance abuse problems and create collaborative approaches that *share* information and resources, rather than require the creation of new ones.

An agency should consider developing:

- Guidelines and requirements for training and orienting personnel to the widespread effects of PTSD and substance abuse with crime victims.
- A rudimentary protocol for identifying crime victims with substance abuse and extra-agency resources for referral.

PROVIDE TRAINING ABOUT CONFIDENTIALITY PROTECTIONS

SPECIFIC TO SUBSTANCE ABUSE

The federal confidentiality law and regulations concerning substance abuse directly resulted from concerns about the social stigma associated with substance abuse, and concerns that people might hesitate to seek treatment if they feared disclosure of their addiction. According to the Center for Substance Abuse Treatment, "the purpose of the law and regulations is to decrease the risk that information about individuals in recovery will be disseminated and that they will be subjected to discrimination, and to encourage people to seek treatment of substance abuse disorders" (CSAT and Brooks 2000).

Professionals who assist victims should be familiar with this federal law and regulations which, according to CSAT, "protect any information about a client who has applied for or received any substance abuse-related assessment, diagnosis, individual counseling, group counseling, treatment, or referral for treatment. . . . Information protected by the federal confidentiality regulations may always be disclosed after the client signs a proper consent form (for minors, however, parental consent must also be obtained in some states). The regulations also permit disclosure without the client's consent in several situations, including during medical emergencies, in communications among program staff, when reporting is mandated as in instances of child abuse or neglect, or when there is a danger to self or others." (Ibid.) The law is codified as 42 U.S.C. §290dd-2; the implementing federal regulations are contained in 42 Code of Federal Regulations (C.F.R.), Part 2.

PROMOTE ACCESS TO SERVICES FOR VICTIMS

In addition to the dual stigma of substance abuse and victimization that may hinder victims from seeking substance abuse treatment services, there are other barriers service providers must seek to overcome, such as the following:

- Victims' lack of health insurance that adequately covers substance abuse treatment or mental health treatment.
- Other financial limitations when, combined with a lack of free substance abuse treatment programs, may preclude victims from seeking treatment.
- Barriers specific to substance abusing women with children, including lack of child care and fear that any disclosure of substance abuse problems may affect custody agreements.
- Potential fears among adults who were victimized as children about disclosing substance abuse problems to, or seeking assistance from, professionals who are viewed as authority figures.
- Cultural considerations that hinder some people's self-perceptions of victimization and/or substance abuse and their likelihood of seeking assistance.
- Gender-specific issues, such as substance abuse clinicians being "less likely to ask men about their childhood abuse and neglect histories, and that men are less likely than women to talk about these histories. Much of the trauma-related research has focused on women, particularly regarding battering, spousal abuse, rape, and incest. As a result, most assessment instruments have been based on women. Overall, there is a lack of gender-specific instruments." (CSAT and SAMHSA 2000, 41).

In identifying barriers to services for victims with substance dependency or abuse issues, victim service providers can collaborate with allied professionals-including substance abuse, mental health, insurance, child protection and culturally-specific service providers and agencies-to eliminate factors that prevent victims from seeking treatment.

ENHANCE THE PROVISION OF DIRECT CLINICAL SERVICES FOR VICTIMS WITH CHEMICAL DEPENDENCIES

Every resource that offers clinical assistance for crime victims should be required to identify and manage the effects of substance abuse in order to create a plan for the client that addresses and seeks to prevent the use or abuse of substances as a technique for coping with trauma. Clinical staff should be thoroughly familiar with the process of assessing a crime victim for the disorders of PTSD and substance abuse. This assessment might include screening instruments that would reliably measure the presence of PTSD and substance abuse. Clinical services would require the simultaneous management of PTSD and substance abuse. While management of substance abuse will take priority, the treatment of the underlying PTSD should begin when the victim has

stabilized, since untreated PTSD creates high risk for the relapse of substance abuse.

There are few controlled studies of victims with these combined disorders to guide practitioners in "staging" interventions specific for PTSD or substance abuse. In the absence of controlled studies, it would be appropriate to offer comprehensive and flexible clinical services for both, instead of an "absolute" protocol for only one.

PROMOTE GREATER UNDERSTANDING OF SUBSTANCE ABUSE ASSESSMENT AND TREATMENT AMONG PROFESSIONALS WHO ASSIST VICTIMS OF CRIME

While victim service providers are not expected to be substance abuse treatment "experts," it is important for them to understand the tools available for substance abuse assessment so that they can ensure that such tools are incorporated into case planning and treatment. According to Dr. Ted Rynearson, there is a crucial need to develop an assessment tool for substance use and abuse that is specific to people who have suffered sudden loss or trauma, including victims. Currently, Dr. Rynearson utilizes the standardized DAST assessment instrument that asks clients a series of thirty-two questions to: identify the use, abuse, and dependence on alcohol and other drugs; determine physical, behavioral, and emotional problems that relate to substance use and abuse; and ascertain the client's perceptions about how others may feel about the client's substance use.

Furthermore, an understanding of the goals of effective substance abuse treatment can help victim service providers and allied professionals know what treatment involves and what the potential outcomes of substance abuse treatment are for their clients. This level of understanding will enhance service providers' ability to explain treatment processes and goals to their victim clients.

The National Institute of Drug Abuse has published a research-based guide that describes the thirteen principles of drug addiction treatment; ten principles specific to this chapter are--

1. *No single treatment is appropriate for all individuals*. Matching treatment settings, interventions, and services to each individual's particular problems (e.g., criminal victimization) and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.
2. *Treatment needs to be readily available*. Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

3. *Effective treatment attends to multiple needs of the individual, not just his or her drug use*. To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.
4. *An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs*. A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.
5. *Remaining in treatment for an adequate period of time is critical for treatment effectiveness*. The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.
6. *Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction*. In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.
7. *Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way*. Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.
8. *Treatment does not need to be voluntary to be effective*. Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.
9. *Possible drug use during treatment must be monitored continuously*. Lapses to drug use can occur during treatment. The objective monitoring of a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.

10. *Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment*. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence (NIDA 11 April 2000).

ADDRESS CHILD/ADOLESCENT VICTIMIZATION AND SUBSTANCE ABUSE ISSUES

Professionals who assist victims of crime should be aware of substance abuse as both a pre- and post-victimization factor for youth. The links between substance abuse and child/adolescent victimization are clear, and research findings offer importance guidance in developing effective prevention and intervention approaches. Collaboration among victim service providers, child protection and justice professionals, and mental health professionals is necessary to achieve this goal. Attention should be paid to:

- Conducting comprehensive assessments of adolescents who use and abuse alcohol and other drugs to determine if a history of maltreatment is a factor in their lives.
- Identifying if child maltreatment in a family context coexists with substance abuse to provide effective interventions that address both issues. Substance abuse can emerge at coexistent levels, i.e., the perpetrator, the victim, or both may be involved with alcohol and/or drugs.
- Coordinating services to high risk youth among child protective service professionals, victim service and justice professionals, educators, pediatric medical practitioners, substance abuse treatment staff, and mental health professionals (Callanan 1999).

PROVIDE SUPPORTIVE SERVICES TO VICTIMS WHOSE SUPPORTIVE INDIVIDUALS ARE SUBSTANCE DEPENDENT

Victims' ability to cope with their trauma is substantially dependent on their level of social support. If people within a victim's support system are dependent on substances, it can have detrimental effects on the victims' psychological and emotional well-being. To address this concern, victim service providers can:

- Implement intake protocols that screen victims for information about the substance abuse behavior of their family members or other loved ones.

- Give victims appropriate referrals for individual or group counseling, and/or local Al-Anon meetings so that the victim can address the emotional, spiritual, and practical issues that arise from the substance abuse (Callanan 1999).

Federal Initiatives

The Substance Abuse and Mental Health Services Administration (SAMHSA) has provided over $7 million in grants to fourteen community-based programs in ten states for a study of women with substance abuse and mental health problems who are victims of violence. Beginning in 1998, each of the programs received about $500,000 per year for three years. A coordinating center was awarded $1.2 million to provide guidance and direction in program development to the 14 grantees.

This two-phase *Women and Violence Study* will generate valuable knowledge on the confluence of violence and co-occurring substance abuse and mental health disorders affecting women and their children. Each of the two phases will run for three years. Research has clearly shown that existing health care systems are not designed, nor are they prepared, to adequately address the problem of these co-occurring disorders in women, the associated violence, and the effects on their children.

This Knowledge Development and Application (KDA) program focuses on women ages eighteen and above with co-occurring disorders who have histories of physical and/or sexual abuse and who are "high-end users" (who have experienced at least two treatment episodes within either substance abuse or mental health systems). Any dependent children of these women will also be included in the program.

Phase one of the study focuses federal support to assist local communities in developing their own strategies to integrate services that address the needs of affected women and their children. Each local community will also develop an appropriate blend of services that will address trauma-related problems experienced by women with co-occurring disorders. Phase two will include implementation of strategies and services from phase one and evaluation of program outcomes. SAMHSA staff will be active participants in all aspects of the cooperative agreements with grantees, serving as collaborators with project directors from the study sites.

The Office for Victims of Crime (OVC) is now engaged in developing a vehicle and process to further clarify and, ultimately, develop initiatives for addressing the relationship between substance abuse and victimization.

Research and practitioner experience indicates that this relationship is significant and appears to have three facets:

- Substance abuse as a pre-victimization factor.
- Substance abuse as a post-victimization factor associated with victim trauma.
- Professionals and volunteers who assist victims and abuse or develop dependencies on alcohol and other drugs as a means to cope with vicarious and secondary trauma.

As a first step, OVC is developed a new text chapter and produced a training film about substance abuse among crime victims and those who serve them for its National Victim Assistance Academy curriculum.

Concurrently, OVC is identifying individuals within the Justice Department, especially VAWO, and within SAMHSA, especially CSAT, who are interested in partnering with OVC in a small Substance Abuse and Victimization Working Group that is envisioned as the vehicle to achieving OVC's ultimate goals in this area. OVC has already partnered with the American Probation and Parole Association (APPA) which has recently engaged its organization in researching this issue to develop a strategy that would provide resources for victim service providers.

The Working Group on Substance Abuse and Victimization will pursue the following long-term objectives:

- Develop structures and linkages to maintain a coalition of organizations that share concerns about substance abuse and victimization.
- Promote public and professional awareness of the relationship of criminal victimization and substance abuse.
- Identify areas where additional information on victims and substance abuse is needed.
- Promote the development and delivery of collaborative approaches to provide comprehensive treatment and access to needed services for victims who are substance abusers or at high risk of abusing substances.
- Promote training and technical assistance about substance abuse and victimization issues to victim assistance personnel, mental health and substance abuse treatment providers, and criminal/juvenile justice professionals.
- Promote cross-training among various disciplines that provide services to victims, and services relevant to substance abuse.

In addition to establishing a Working Group, OVC plans to sponsor a series of focus groups dealing with substance abuse and victimization to

clarify the issues involved for both victims and providers, and to develop recommendations for further actions to address these issues. Input from a multifaceted Working Group would greatly enhance OVC's ability to draw from a more diverse cross-section of people working with this issue, and foster state and Federal follow-up capability.

Conclusion

Finally, it should be emphasized that this attention to and service for psychiatric disorders with crime victims is viewed as crime-related. PTSD and substance abuse are common responses to the trauma of crime and should first be viewed as secondary effects of the intolerable horror and helplessness forced upon these people. Recovery for victims cannot begin until and unless our understanding and service is based upon this compassionate insight-our recognition that given the same circumstances, we might be in the same predicament.

Promising Practices

- *Project Heartland* is an unprecedented program of disaster mental health services activated by the Oklahoma Department of Mental Health and Substance Abuse Services in direct response to the bombing of the Murrah Federal Building in April 1995. The program was funded from May 1995 through February 1998 by the Federal Emergency Management Agency in order to provide crisis counseling and intervention, support groups, outreach, and consultation/education to individuals affected by the bombing disaster. Since people are often reluctant to seek mental health services after a traumatic event, the program's activities were designed to be accessible not only at the Project Heartland Center, but in clients' homes and workplaces, schools, and other locations. In March 1997, Project Heartland received additional funding from the U.S. Department of Justice to cover the expense of stationing counselors in Safe Havens in Denver and Oklahoma City to provide services, as needed, for survivors and family members viewing the trial proceedings (Project Heartland 1999).

    - Those who receive Project Heartland services can be grouped into two general categories. "Clients" are defined as those who received direct, personalized attention from a Project Heartland counselor in individual, group, or marital therapy sessions; in an emergency crisis intervention; in support group meetings; or through advocacy or referral efforts. "Other recipients" are defined as persons who received supportive services at the trial-related Safe Havens or who received less personalized services, such as

contacts by outreach workers offering educational materials and information about services; debriefing sessions as part of workplace groups; or educational seminars on topics such as grief or traumatic stress. From June 1, 1995, when data collection began, through December 31, 1998, Project Heartland provided services to 8,999 clients and 188,426 other recipients.

- *Advocacy for Women and Kids in Emergencies (AWAKE)*. Children's Hospital in Boston, MA developed AWAKE to serve battered women who also have substance abuse issues. In addition to the traditional services of counseling, legal advocacy, and emergency housing, this program offers drug and alcohol recovery services. Contact: Jennifer Robertson, Director, AWAKE, Children's Hospital, 300 Longwood Avenue, Boston, MA 02115 (617-355-6000), e-mail Robertson@A1.tch.harvard.edu.
- *Homicide Support Project*, Seattle, WA. The purpose of this program is to train professionals across the country to provide effective assistance to crime victims experiencing traumatic grief and loss. Supported by a VOCA grant, the Homicide Support Project team (consisting of a psychiatrist, a crisis counselor, bereavement specialists, victim assistance advocates, and prosecuting attorney) has written a training manual. It includes a battery of screening instruments to guide clinicians in assessing and recommending appropriate intervention for substance abuse, PTSD, depression, and other mental health problems caused by or co-existing with the victim's traumatic grief. Contact: Dr. Ted Rynearson (206-223-6600).
- *Greentree Shelter*, Montgomery County, MD. Greentree Shelter serves homeless families, primarily single mothers and their children. A disproportionate number of these single mothers reports histories of pervasive sexual abuse as children. Substance abuse by many of the women and their partners and long-standing patterns of domestic violence complicate recovery. Unlike many homeless or domestic violence shelters, at Greentree Shelter, families are not evicted because of an alcohol- or other drug-related relapse. The mothers receive comprehensive services including individual and group counseling, child care and after-school care, substance abuse referrals, education, and prevention services. Contact: Sheryl Brissett-Chapman, Executive Director, Baptist Home for Children and Families, 6301 Greentree Road, Bethesda, MD 20817 (301-365-4480, extension 115).
- *American Probation and Parole Association (APPA) National Working Group.* In 1999, APPA instituted a National Working Group to address not only the issue of victims and substance abuse, but also the critical topic of substance abuse among professionals who

serve victims, primarily as a consequence and response to the stress and vicarious trauma associated with professions such as victim assistance and criminal or juvenile justice. The APPA National Working Group is establishing a national network of victim services, justice, mental health, and allied professionals concerned about these issues, and conducting an exhaustive literature review to establish a scientific basis for prevention and intervention responses.

- *Health Practitioner Intervention Program*. The Commonwealth of Virginia Department of Health Professions has contracted with a private firm to provide confidential services for the health professional (including social workers) who may be impaired by any physical or mental disability or who suffers from chemical dependency. The purpose of the Health Practitioner Intervention Program is "to increase the number of practitioners who will seek assistance as an alternative to disciplinary action, thereby enhancing public protection, as well as providing an alternative for the practitioner." Available services include assessment, evaluation, referral, intervention, coordination, monitoring, and advocacy.

SOUTH CAROLINA RESOURCES

Obtaining access to good treatment for substance abuse/dependence is difficult in general, but finding treatment providers who are also knowledgeable about the special problems of crime victims with substance use problems is particularly challenging. South Carolina is no exception to this national problem. Having said that, South Carolina does have some excellent resources.

One major resource is the Department of Alcohol and Other Drug Abuse Services (DAODAS). DAODAS is the SC cabinet-level agency charged with ensuring the provision of quality services to prevent or reduce the negative consequences of substance use and addictions. The DAODAS website (http://www.daodas.state.sc.us/) provides information about substance abuse/dependence treatment services that are available at the county and regional levels.

South Carolina has also been at the forefront nationally in basic and clinical research regarding the causes, assessment, and treatment of substance use disorders. In particular, South Carolina researchers/clinicians have done some of the pioneering research documenting the relationship between child maltreatment and criminal victimization, PTSD, and substance use problems. Several researchers at the National Crime Victims Research and Treatment Center at the Medical University of South Carolina have done this work that is cited elsewhere in this chapter.

The Medical University of South Carolina also has two other groups of basic and clinical researchers who have made relevant contributions. The Center for Drug and Alcohol Programs (CDAP) is a nationally recognized expert in basic research on the causes and consequences of addiction to alcohol and other drugs. CDAP is also well-known for its research to find which medication and/or psychotherapy treatment are most effective for substance use problems. CDAP also offers inpatient and outpatient substance abuse treatment. The website for CDAP is: http://www.muschealth.com/cdap/. The Clinical Neuroscience Division (CND) in the Department of Psychiatry and Behavioral Sciences at MUSC has several faculty members who have focused specifically on developing and evaluating treatments for substance abusing women who also have PTSD. The CND website is: http://www.musc.edu/psychiatry/research/cns/cns_home.htm

Substance Abuse and Victimization Self-Examination

1. Define the differences between (1) substance use, (2) substance dependence, and (3) substance abuse.

2. Explain substance use or abuse as applied to three different victim populations (e.g., adolescent victims, child victims, homicide victims).

3. Describe the difference between substance abuse as a correlative, as opposed to a causative, factor in victimization.

4. Explain how substance abuse can be a pre- and postvictimization factor.

5. List three positive steps that victim advocates can take to assist crime victims with substance abuse.

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OVC provides links to other Web sites as a convenience to its visitors and tries to ensure that the links are current. The inclusion of a link on this document does not constitute an official endorsement, guarantee, or approval by OVC. OVC neither endorses, has any responsibility for, nor exercises any control over the organizations' views or the accuracy of the information contained in those pages.

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